STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G139	A. BUILDING _____ B. WING _____	01/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANAGER PLACE	2309 C STREET SW CEDAR RAPIDS, IA 52404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the Qualified Intellectual Disability Professional (QIDP) failed to effectively integrate, monitor and coordinate Individual Program Plans (IPPs) in order to meet client needs. This affected 3 of 4 sample clients (Client #1, Client #2 and Client #3). Findings follow: 1. a) Observations on 1/2/18 and 1/3/18 (throughout the survey) revealed Client #1 did not wear a soft shell helmet. The helmet remained in the client's bedroom and no prompts were observed by the surveyor to wear a helmet. Record review on 1/3/19 revealed Client #1's Individual Program Plan (IPP) addressing safe behaviors. According to the IPP, the client should be prompted each morning and throughout the day to wear a soft helmet. The use of the helmet came as a result of a diagnosis of concussion on 9/1/18. According to the Medication Administration Record (MAR) for November, 2018 and December) the client refused all attempts to wear the helmet. When interviewed on 1/3/18 at 10:00 a.m. the on-site school Facilitator stated Client #1 wore a soft-shell helmet at school due to past concussion. The client applied the helmet upon arrival at school without difficulty. b) Observations on 1/2/18 and 1/3/18 (throughout the survey) revealed Client #1 did not wear	W 159	See attached POC 3/31/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	Continued From page 1 eyeglasses. Staff were not observed to prompt the client to wear eyeglasses. Record review on 1/3/18 revealed Client #1's program started on 11/1/18 addressing the wearing eyeglasses and maintaining eyeglasses by not breaking or losing them. The program directed staff each morning and throughout the day to prompt the client to wear his eyeglasses. The client should be prompted to wear them at least every 30 minutes. When interviewed on 1/3/18 at 8:05 a.m. the Certified Medication Aide stated she did not know anything about the client's eyeglasses. When interviewed on 1/3/18 at 8:06 a.m. the Youth Service Worker stated she heard Client #1's eyeglasses had been lost. When asked for how long, the staff responded since she began her employment approximately three months ago. When interviewed on 1/3/18 at 10:00 a.m. the on-site school Facilitator stated she was unaware Client #1 wore eyeglasses and they were not available at school. Record review of Client #1's Physician's Referral Forms documented on 8/24/18 Client #1 received eyeglasses. The eyeglasses were repaired and returned to the facility staff on 9/5/18 and 11/20/18. Review of the MAR for November, 2018 documented the client's eyeglasses were either lost or he refused to wear them during the month. No documentation was completed on the MAR in December, 2018. The data collection sheet for November and December 2018 documented the	W 159		

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W 159	Continued From page 2 client's eyeglasses were lost for both months. Data summary for November, 2018 noted the client failed to meet his objectives (performing at 0%) for wearing and maintaining (breaking or losing) his eyeglasses. No data summary for December, 2018 was available at the time of the survey. When interviewed on 1/3/18 at 3:45 p.m. QIDP A confirmed staff should prompt Client #1 to wear his helmet and eyeglasses as directed in the IPPs. She stated she was unaware the eyeglasses were lost, as well as, the client refused to wear his soft-shell helmet. QIDP A stated these programs should be monitored and revised since the client refused to comply. She concurred the wearing of the helmet was extremely important due to past issues with concussions. She also stated to her knowledge there had been no communication with Client #1's school regarding the wearing of eyeglasses. 2. Record review on 1/3/19 revealed Client #2's Individual Program Plan (IPP) addressing healthy and effective emotion regulation skills. The program outlined several behavioral objectives including goal 1F: Client #2 "will use a coping skill to handle strong emotions instead of self-harming with 1 verbal prompts in 75% of trials for 3 consecutive months." Self-harming was defined as biting self, scratching self and banging his head. The program directed staff to collect daily data throughout each shift and to refer to the data sheet. Review of the 30 day summaries completed by the QIDP for October, 2018 and November, 2018 failed to include a review of the client's goal. Review of data sheets for October, November and December, 2018 also	W 159		

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W 159	Continued From page 3 failed to include a mechanism to collect the appropriate data. Review of Client #2's Individual Habilitation Plan (IHP) dated 12/14/18 documented data had not been collected during the baseline time period as well as July, August, September and October, 2018 due to an error. Review of Client #2's IPP addressing appropriate interactions with peers and adults. The program outlined two behavioral objectives including goal 2B: The client "will display appropriate boundaries with peers and staff 75% of trials for 3 consecutive months." The program failed to direct staff on documentation methods for the goal. Review of Client #2's data summary completed by the QIDP for October, 2018 and November, 2018 did not include a review of Goal 2B. Review of data sheets for October, November and December, 2018 also did not include information for staff to collect data. In addition, the Client #2's IHP dated 12/14/18 failed to include information regarding the goal. When interviewed on 1/3/18 at 2:30 p.m. QIDP B confirmed data had not been obtained on all goals for Client #2. She stated she was unaware of the lack of data collection and the goals were not addressed as a part of the QIDP review process. 3. Record review on 1/03/19 revealed Client #3 was admitted to the facility on 5/18/18. The 30-day interdisciplinary meeting to develop the IHP was held on 6/11/18. The team identified priority needs and developed program plans to meet those needs. Client #3 had specific target behaviors identified as part of his IPP to "safely manage overwhelming feelings". One objective	W 159		

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W 159	Continued From page 4 was to "use coping skills to handle strong emotions instead of becoming destructive with 1 verbal prompt in 75% of trials for 3 consecutive months". Another objective was to "display appropriate interactions with peers (no incidents of threatening, instigating, or arguing with peers, use coping skills when frustrated by others) with 3 or less prompts in 75% of trials for 3 consecutive months". A review of the monthly data summaries for each objective revealed there was no data collected on either of these two objectives from the start of the programs (June 2018) through November, 2018 (the most recent month of data summaries). According to the monthly data summaries for the two objectives from June, 2018 through November, 2018, "Due to an error, data was not collected this month." When interviewed on 1/03/19 at 9:30 a.m., the Clinic Supervisor and QIDP A stated a previous QIDP was responsible for reviewing the data summaries and had apparently overlooked the two objectives noted. The Clinic Supervisor said the facility was not aware of the oversight for several months.	W 159		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAG0138	A. BUILDING: _____ B. WING _____	01/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANAGER PLACE	2309 C STREET SW CEDAR RAPIDS, IA 52404

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C 146	50.7(3) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(3) When there is an act that causes major injury to a resident or when a facility has knowledge of a pattern of acts committed by the same resident on another resident that results in any physical injury. For the purposes of this subrule, " pattern " means two or more times within a 30-day period. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the Department of Inspections and Appeals (DIA) when a resident had a pattern of aggression which resulted in injury to peers, as required by Iowa Code 481 IAC 50.7(3). This affected 4 of 8 clients residing in the Terry Cottage (Clients #3, #4, #5 and #6). Finding follows: Record review on 1/03/19 revealed a Patient Progress Note dated 11/02/18, indicated Client #5 aggressed toward Client #3. According to the Progress Note, Client #5 pushed Client #3, causing Client #3 to fall backwards and strike his back on a desk. Staff noted Client #3 had a small bruise on his back as the result of the incident. A follow-up nursing assessment noted an abrasion to Client #3's lower right back. Record review on 1/03/19 revealed a Patient	C 146		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 146	Continued From page 1 Progress Note dated 11/20/18, which indicated Client #5 slapped and hit Client #4 during an altercation. According to the Progress Note, Client #4 had redness on her upper right arm and "Bruising seems likely." There was no follow-up documentation regarding whether a bruise developed. Record review on 1/03/19 revealed a Patient Progress Note dated 11/30/18, which indicated Client #5 "attacked" Client #6 and left several scratch marks on Client #6's face. Police were called to assist with the incident. When interviewed on 1/07/19 at 10:15 a.m. Qualified Intellectual Disability Professional (QIDP) A stated she and QIDP B monitored peer to peer aggression. QIDP A said she was aware of the requirement for agencies to report when a client had two or more acts of aggression within 30 days which caused injury, but it was her understanding the injuries had to be significant and did not include scratches and bruises. The QIDP stated the agency was not able to locate a policy regarding peer to peer aggression causing injury, but acknowledged the agency should follow DIA guidelines and state regulations regarding reporting the incidents.	C 146		

OK 3/20/19

✓ 3/20/19

TANAGER PLACE

YOUR CHILD : OUR FOCUS

DIA Corrective Action Plan/Facility Response January 2019

C146

Tanager Place will implement policy which defines and clarifies the definition of injury in regards to regulatory requirement 50.7(3). Physical injury shall be defined as any injury lasting longer than 24 hours or injury that requires physician treatment.

Completion Date: 1/11/19

Policy procedures will be reviewed and potential improvements will be implemented. Review will include procedures for notification, documentation, and follow- up.

QIDP and Program Manager reviewed and made modifications to peer to peer incident documentation protocols and monitoring system to ensure patterns of injury and/or major injury are monitored closely, ensuring notification of director or director's designee within 24 hours.

Completion Date: 1/18/19

Program staff will receive updated training regarding regulatory compliance of 50.7(3) including training on Tanager Places policy and procedures for 50.7(3).

Completion: 2/15/19

W159 #1

QIDP will ensure the specific teaching interventions and staff protocols for increasing the tolerance of soft-helmet utilization are integrated into the currently existing Individual Program Plan (IPP) to promote appropriate use of and care for soft helmet. These steps will be reviewed with staff.

Program staff will document the current status (lost, broken, level of prompting to wear) of consumer's soft helmet each shift. QIDP will review individual data indicating current status of soft helmet weekly during team meeting with program staff. If the soft helmet is determined to be missing, broken, or damaged, QIDP will work with the nursing department to ensure that the soft helmet is repaired and/or replaced as quickly as possible, ensuring that this consumers has access to helmet.

QIDP will ensure that consumer's IPP, including teaching and behavioral interventions, as well as individualized incentives, if appropriate, are reviewed quarterly with program staff. Most recent review of this program plan with program staff was completed on 1/17/19.

Completion Date: 1/31/19 and ongoing

QIDP will review individual data indicating the current status (lost, broken, level of prompting to wear) of all consumers' eye glasses weekly during team meeting with program staff. If eye glasses are

2309 C St. SW
Cedar Rapids IA 52404
Phone: (319) 365-9164 • Fax: (319) 365-6411
www.tanagerplace.org
Accredited by the Council on Accreditation

determined to be missing, broken, or damaged, QIDP will work with the nursing department to ensure that eye glasses are repaired and/or replaced as quickly as possible, ensuring that consumers have access to eye glasses.

QIDP will ensure that each consumer's IPPs include teaching and behavioral interventions, as well as individualized incentives, if appropriate and that they are reviewed at least quarterly with program staff.

A tracking system will be implemented to ensure daily monitoring of all consumers' eye glasses. This system will be placed in the MAR for at least four-times daily completion, and will indicate the current status of consumer glasses (wearing, missing, broken, and refusing). The duty of completing this tracking system will be completed by CMA's; compliance and completion will be ensured by Program Supervisor.

Completion Date: 1/30/19 and ongoing.

W159 #2-3

QIDP will review current individualized program plans to ensure data collection for priority goals and objectives. QIDP will ensure that data collection methods are in place at the time of a new goal, programming, and/or objective implementation, and will provide updated data collection methods and programming to the milieu.

Completion Date: 1/30/19

Clinical Supervisor and QIDP(s) will conduct file reviews quarterly, ensuring improved oversight of data collection completion and methods.

Completion Date: 3/31/19 (quarter 1) and ongoing.

Respectfully Submitted,

Michelle Allmandinger
Inpatient Services Director, Tanager Place
319-365-9165 ext. 399
mallmandinger@tanagerplace.org

Kristin Moore, LBSW, QIDP
Tanager Place ICF/ID
319-365-9165 ext. 402
kmoore@tanagerplace.org